SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*46023*
Company Tracking Number:	*A3099AC-AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.006 Plan F (High) 2010*
Product Name:	*2010 Med Supp AR Corp - Plan HdF*		
Project Name/Number:	*2010 Med Supp AR Corp - Plan HdF/A3099AC-AR*		

Filing at a Glance

Company: American Republic Corp Insurance Company

Product Name: 2010 Med Supp AR Corp - Plan HdF	SERFF Tr Num: AMRP-126675679	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 46023
Sub-TOI: MS08I.006 Plan F (High) 2010	Co Tr Num: A3099AC-AR	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Authors: Susan Falk, Sarah Shives, Jamie Mueller, Michele Kulish Danielson, Colletta Maddy	Disposition Date: 07/13/2010
	Date Submitted: 06/23/2010	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date: 07/13/2010

State Filing Description:

General Information

Project Name: 2010 Med Supp AR Corp - Plan HdF	Status of Filing in Domicile:
Project Number: A3099AC-AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/13/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/13/2010
Deemer Date:	Created By: Sarah Shives
Submitted By: Sarah Shives	Corresponding Filing Tracking Number:

Filing Description:

Please see the Cover Letter under the Supporting Documentation tab.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*46023*
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Sarah Shives,
601 6th Ave.
Des Moines, IA 50309
sarah.shives@americanenterprise.com
515-245-2083 [Phone]

Filing Company Information

American Republic Corp Insurance Company	CoCode: 67679	State of Domicile: Nebraska
P O Box 2780	Group Code: 3527	Company Type: Life and Health
Omaha, NE 68103-2780	Group Name: American Enterprise	State ID Number:
(800) 987-8988 ext. [Phone]	FEIN Number: 23-1609793	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$50 for policy form + $50 for rates= $100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Corp Insurance Company	$100.00	06/23/2010	37438210

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	07/13/2010	07/13/2010

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
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Project Name/Number:	*2010 Med Supp AR Corp - Plan HdF/A3099AC-AR*		

Disposition

Disposition Date: 07/13/2010
Implementation Date: 07/13/2010
Status: Approved-Closed
Comment: This approval is subject to the following:

• Increases will not be given more frequently than once in a twelve-month period;

• Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Cover Letter	Accepted for Informational Purposes	Yes
Form	Plan High Deductible F	Approved	Yes
Rate	Rates	Approved	Yes
Rate	Area Adjustment Factors	Approved	Yes

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: A3099AC-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/13/2010	A3099AC-AR	Policy/Contract/Fraternal Certificate	Plan High Deductible F	Initial		60.700	A3099AC-AR - Plan High Dedt F.pdf

American Republic Corp
Insurance Company
P.O. Box 2780 • Omaha, Nebraska 68103-2780
A Stock Insurance Company

Medicare Supplement Policy – Benefit High Deductible Plan F

Benefits Provided by This Policy are Subject to Changes Made in Medicare.

We have issued this policy based on: (a) your application for it; and (b) your payment of the first premium on or before the Policy Date. The first premium and the Policy Date are shown on Schedule of Benefits.

Read Your Policy Carefully! This policy is a legal document between you and us.

Part A – 30-Day Right to Examine Policy

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

Part B – Guaranteed Renewable; Premiums Subject to Change

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may not change the premiums unless we do so on all policies of this form issued to persons of your class. We will notify you of the new premium at least 31 days before the first premium due date after which the changes take effect.

Medicare Changes – The benefits of your policy change when the Medicare deductibles and copayment amounts you are required to pay are changed. We may also change the premiums (with state insurance department approval) when the benefits change.

The provisions on the following pages are part of this policy.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the Policy Date.

[Michael E Abbott — President Mary K Durand — Secretary]

Notice to Buyer – This policy may not cover all of your medical expenses.

Table of Contents

Page

Schedule of Benefits

COVERED PERSON (S):

INSURED [John A. Doe] ISSUE AGE: [-age 65]

COVERED SPOUSE [Jane B. Doe] ISSUE AGE: [65]

POLICY NUMBER: [12345678]

POLICY DATE: [JANUARY 1, 2010]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): $ [####]

FIRST POLICY ANNIVERSARY:

PREMIUMS:

FIRST PREMIUM PAID: $ [XXX.XX]

PREMIUM FREQUENCY: [Monthly, Quarterly, Semi-Annually, Annually]

CLASSIFICATION: [John A. Doe] [Standard, Preferred]
[Jane B. Doe] [Standard, Preferred]

Part C – Definitions

Some words used in your policy have a special meaning. We have defined them below. Also, the words "we," "our" and "us" refer to American Republic Corp Insurance Company. The words "you" and "your" refer to the insured person named on the Schedule of Benefits.

"Age" means your age on your last birthday.

"Annual High Deductible" means the amount the covered person must satisfy each calendar year before we begin paying benefits under this contract. The annual high deductible includes Out-of-Pocket expenses, other than premiums, for service covered as benefits under this policy and shall be in addition to any other specific benefit deductibles. Expenses incurred before the Policy Date of this coverage will not be applied to this deductible.

A **"Benefit Period"** starts the first time a covered person enters a hospital on or after the Policy Date. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility for at least 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A **"Calendar Year"** begins January 1 and ends December 31 each year.

"Class" means the factors that went into making up the premium rate when coverage was issued. In addition to the plan of insurance, those factors include age and geographic region.

"Covered Person(s)" means you and/or your covered spouse as approved by us, or added to coverage by endorsement, provided coverage has not been terminated.

"Covered Spouse" means your lawful spouse, as named in the application and approved by us, or as added to coverage by endorsement, provided coverage has not been terminated.

"Hospice Care" means treatment in a hospice program as defined by Medicare.

"Hospital" means an institution which meets Medicare's definition of a hospital.

"Injury" means accidental bodily injury which occurs while this policy is in force.

"Loss" means the Medicare eligible expenses incurred by a covered person resulting from a covered sickness or injury.

"Medicaid" means Title XIX of the Social Security Amendments of 1965, as amended.

"Medicare" means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

"Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

"Physician" is a physician meeting Medicare's definition of physician.

"Respite Care" is treatment that meets Medicare's definition of respite care.

"Sickness" means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force.

Part D – Benefits

We will pay benefits for the following items of expense a covered person incurs and that are approved but not paid for by Medicare Parts A and B after the covered person has satisfied their annual high deductible each calendar year. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. Medicare eligible expenses must be incurred during the benefit period while this policy is in force.

Basic (Core) Plan Benefits

a. Medicare Part A Hospital Services and Supplies Expenses
    1. Part A Medicare eligible expenses for hospitalization from the 61st through the 90th day in any Medicare benefit period;
    2. Part A Medicare eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and
    3. When all Medicare hospital inpatient coverage and lifetime reserve days are used up, we will pay 100% of the Part A Medicare eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the covered person for any balance.
b. Medicare Part A and Part B Blood Deductibles – Coverage under Medicare Parts A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.
c. Medicare Part B Medical Insurance – After the Medicare Part B Deductible, we will pay the Medicare Part B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.
d. Hospice Care – We will provide coverage of cost sharing (Medicare copayment or coinsurance amounts) for all Part A Medicare eligible expenses for hospice care and respite care. In order to receive this benefit, you must meet Medicare's requirements including a physician's certification of terminal illness.

Additional Benefits

a. Medicare (Part A) Hospital Insurance Deductible – We will pay the Medicare (Part A) Inpatient Hospital Insurance Deductible.
b. Skilled Nursing Facility Expenses – We will pay the actual billed charge up to the Medicare daily coinsurance charge (deductible) for days 21 through 100 of a Medicare-approved skilled nursing facility stay.
c. Medicare (Part B) Medical Insurance Deductible – We will pay the Medicare (Part B) Medical Insurance Deductible.
d. 100% Medicare Part B Excess Charges – We will pay up to 100% of the excess charge for eligible expenses approved but not paid by Medicare. "**Excess charge**" is the difference between the actual billed amount, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
e. Medically Necessary Emergency Care in a Foreign Country – We will provide coverage to the extent not covered by Medicare for 80% of billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country.

Benefits will be paid if the care would have been covered by Medicare if provided in the United States. Such care must begin during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum of $50,000.

"Emergency care" means care needed immediately because of an injury or a sickness of sudden and unexpected onset.

Part E – Benefit Changes

Benefits will change automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors.

Part F – Benefit Extensions

Termination of coverage shall be without prejudice to a continuous loss which commenced while this policy was in force. Extension of benefits beyond the period this policy was in force is:

a. subject to the covered person's continuous total disability;
b. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
c. limited to the duration benefits would have been paid had this policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Part G – Exclusions

We will not pay benefits for:

a. services for which a charge is normally not made when there is no insurance;
b. expense incurred before the Policy Date; or
c. that portion of expense incurred which is paid for by Medicare.

Part H – Premium Provisions

Premium Payment – The premium must be paid on or before the date it is due or during the grace period.

Grace Period – The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

Lapse – This policy will go out of force if the premium is not paid by the end of the grace period.

Reinstatement – If this policy should lapse, we, or an agent we specifically authorize to accept premiums, may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other

rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

Suspension and Reinstitution of Coverage

Suspension of Coverage

Eligibility for Medicaid **–** Benefits and premiums under this policy shall be suspended at a covered person's request for a period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). The covered person must notify us within 90 days after becoming entitled to such assistance. Upon receipt of timely notice, we will return that portion of the premium for the period of time the covered person is eligible for Medicaid. The refunded premiums will be reduced by the amount of claims paid for the period the covered person is eligible. If a covered person loses entitlement to medical assistance (Medicaid) during a period of suspension, this policy will be automatically reinstituted. This will be effective the date of termination of the entitlement. The covered person must provide us with notice of the loss of the entitlement within 90 days after the date of the loss and pay the premium attributed to the period effective as of the date of termination of entitlement.

Group Health Plan – Benefits and premiums under this policy shall be suspended, at a covered person's request, (for any period that may be provided by federal regulation) if the covered person is entitled to benefits under section 226(b) of the Social Security Act as amended; and covered under a group health plan (as defined in section 1862(b) (1) (A) (v) of the Social Security Act, as amended). If a covered person loses coverage under the group health plan during a period of suspension, this policy will be automatically reinstituted. This will be effective as of the date of loss of coverage. The covered person must provide us with notice of loss of coverage within 90 days after the date of the loss.

Reinstitution

Upon reinstitution:

a. there will be no additional waiting period with respect to treatment of preexisting conditions;
b. coverage will be substantially equivalent to coverage in effect before the date of the suspension; and
c. premiums will be classified on terms that are at least as favorable to the covered person as the premium classification terms that would have applied to the covered person had the coverage not been suspended.

Part I – How Your Covered Spouse May Convert to His/Her Own Policy

If you and your spouse get divorced from each other, you may both continue your insurance. Either you or your covered spouse may obtain a separate policy without having to provide us evidence of insurability. The request for the new policy must be made within 31 days after you or your spouse are removed from the coverage of this policy. The new policy will be effective on the date coverage ended under this policy. We will not issue a new policy to anyone who is not a permanent resident of the United States.

Part J – How to File a Claim

Notice of Claim – We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may provide us with the notice, or you can have someone provide it for you. The notice should include your name and either your policy number or identification number. The notice should be sent to us at: American Republic Corp Insurance Company, [P.O. Box 2780, Omaha, Nebraska 68103-2780], or to any of our agents.

Claim Forms – When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of

claim if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses are incurred.

Proof of Your Claim – We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be provided to us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

Part K – Payment of Claims Provisions

Payment of Claims – Benefits are paid to the covered person. Any benefits unpaid at the covered person's death we may pay to their beneficiary (if one is named); otherwise, we may pay them to the covered person's estate. We may also pay up to $1,000 of unpaid benefits to any of the covered person's relatives we deem properly qualified to receive them. We will be discharged of liability for payments we make in good faith to the covered person's relatives.

Time of Payment of Claims – All benefits due are paid as soon as we receive the covered person's proper written proof of loss.

Subrogation – To the extent allowed by law, we will be subrogated to all rights of recovery that a covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us that were incurred by the covered person as a result of acts or omissions of a third party for which a third party or insurer is or may be responsible to the covered person. Medicare claims or liens take priority over our subrogation rights. However, following Medicare, our right to repayment shall be a first priority lien against any recovery by the covered person and is to be paid regardless of whether the covered person is fully compensated. Our right to repayment is enforceable regardless of whether the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits we paid to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

Part L – General Provisions

Entire Contract; Changes – This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of ours may make a change and the change must appear in writing as a part of this policy.

Time Limit on Certain Defenses – Unless based on fraudulent misstatement by you on the application, we will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the Policy Date because of misstatements.

Physical Examination – We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

Legal Action – Before you can bring a legal action to recover under this policy, you must wait for at least 60 days after you have given us due proof, in writing, of the particular claim for benefits. Any legal action under this section must be brought by you within three years of the date we receive your proof of the claim on which you intend to pursue the legal action.

Other Insurance With Us – The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any part of Medicare (Part A and/or Part B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

Conformity With State Law – If this policy does not comply with the laws of the state where you live on the Policy Date shown on the Schedule of Benefits, we will treat it as if it had been amended to comply.

Misstatement of Age – If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

Premium Refund at Death – If the covered person dies while this policy is in force, we will refund part of your premium. The refund will be the unused premium beginning with the first policy month after the covered person's date of death.

Change of Beneficiary – The covered person may change the beneficiary at any time by providing us written notice. The covered person does not need the consent of the beneficiary to make this or any other change, unless the covered person has made a designation that cannot be changed.

Assignment – If the covered person assigned the benefits to someone else, we will pay them to the assignee instead of to the covered person, the covered person's beneficiary, or the covered person's estate. We will not be bound to an assignment until we receive a valid written assignment.

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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 07/13/2010	Rates	A3099AC-AR	New		02 AR A3099AC2010 RATES.pdf
Approved 07/13/2010	Area Adjustment Factors	A3099AC-AR	New		04 RELATIVITY FACTORS.pdf

American Republic Corp Insurance Company
2010 Annual Community Age Rates
Form: A3099AC
Plan HDF
Arkansas

	STANDARD ANNUAL COMMUNITY SINGLE	STANDARD ANNUAL COMMUNITY COUPLE
64-99	947.81	819.14

Semi-Annual	=	.5 X Annual
Quarterly	=	.25 X Annual
Monthly Direct	=	.087 X Annual
Monthly PAC	=	.08334 X Annual

Zip Code Area Factors

71700-71799	0.99
71800-71899	1.04
72200-72299	1.15
72300-72599	1.04
72600-72999	0.99
ALL OTHERS	1.10

A factor of 0.85 is applied to all Preferred class policies.

American Republic Corp Insurance Company
Residence Adjustment Factors
For policy forms: A3099AC

State	Zip Code	Area Factor
Alabama	35000-35299	1.14
Alabama	35400-35499	1.03
Alabama	35500-35599	1.14
Alabama	35700-35999	1.03
Alabama	36700-36999	1.03
Alabama	ALL OTHERS	1.08
Alaska	ALL OTHERS	0.92
Arizona	85000-85099	1.06
Arizona	85200-85399	1.00
Arizona	85500-85599	1.00
Arizona	85700-85999	1.00
Arizona	86400-86499	1.06
Arizona	ALL OTHERS	0.94
Arkansas	71700-71799	0.99
Arkansas	71800-71899	1.04
Arkansas	72200-72299	1.15
Arkansas	72300-72599	1.04
Arkansas	72600-72999	0.99
Arkansas	ALL OTHERS	1.10
California	90000-91999	1.66
California	92000-92199	1.41
California	92200-92599	1.35
California	92600-92999	1.66
California	93000-93099	1.35
California	93100-93299	1.23
California	93300-93399	1.29
California	93400-93499	1.23
California	93500-93599	1.41
California	93600-93999	1.05
California	94000-94299	1.35
California	94300-94399	1.17
California	94400-94999	1.23
California	95000-95399	1.17
California	95400-95599	1.11
California	95600-95699	1.23
California	95700-96199	1.17
California	ALL OTHERS	1.23

Colorado	80000-80699	1.17
Colorado	80700-80799	1.00
Colorado	80800-80999	1.12
Colorado	81100-81399	1.00
Colorado	81400-81599	0.95
Colorado	81600-81699	1.00
Colorado	ALL OTHERS	1.06
Connecticut	ALL OTHERS	1.19
Delaware	19700-19899	1.12
Delaware	19900-19999	1.06
Delaware	ALL OTHERS	1.12
District Of Columbia	ALL OTHERS	1.14
Florida	32700-32899	1.49
Florida	33000-33499	1.75
Florida	33500-33799	1.49
Florida	34200-34299	1.49
Florida	34600-34699	1.49
Florida	34900-34999	1.75
Florida	ALL OTHERS	1.30
Georgia	30000-30099	1.13
Georgia	30300-30399	1.13
Georgia	30500-30799	1.02
Georgia	31100-31199	1.13
Georgia	31300-31699	1.13
Georgia	31700-31999	1.02
Georgia	ALL OTHERS	1.08
Hawaii	ALL OTHERS	0.98
Idaho	ALL OTHERS	1.07
Illinois	60000-60399	1.40
Illinois	60400-60599	1.22
Illinois	60600-60899	1.40
Illinois	61000-61199	1.06
Illinois	61500-61699	1.16
Illinois	61700-62099	1.06
Illinois	62200-62399	1.06
Illinois	62400-62499	1.06
Illinois	62500-62599	1.06
Illinois	62700-62799	1.06
Illinois	ALL OTHERS	1.19

Indiana	46000-46099	1.26
Indiana	46100-46199	1.21
Indiana	46200-46299	1.26
Indiana	46300-46499	1.32
Indiana	46900-46999	1.15
Indiana	47100-47199	1.21
Indiana	47500-47899	1.15
Indiana	ALL OTHERS	1.10
Iowa	50000-50399	0.97
Iowa	50500-50599	1.07
Iowa	50700-50799	1.07
Iowa	50800-50899	0.97
Iowa	51300-51399	1.07
Iowa	51500-51599	1.07
Iowa	52100-52199	0.97
Iowa	52500-52599	0.97
Iowa	52600-52699	1.07
Iowa	ALL OTHERS	1.03
Kansas	66000-66099	1.16
Kansas	66100-66299	1.21
Kansas	66600-66699	1.16
Kansas	67200-67299	1.21
Kansas	ALL OTHERS	1.11
Kentucky	ALL OTHERS	1.13
Louisiana	70000-70199	1.26
Louisiana	70400-71199	1.20
Louisiana	ALL OTHERS	1.14
Maine	ALL OTHERS	1.01
Maryland	ALL OTHERS	1.14
Massachusetts	01400-01899	1.13
Massachusetts	01900-02099	1.19
Massachusetts	02100-02299	1.25
Massachusetts	ALL OTHERS	1.08
Michigan	48000-48199	1.31
Michigan	48200-48299	1.43
Michigan	48300-48399	1.31
Michigan	48400-48499	1.25
Michigan	48500-48599	1.31
Michigan	48600-48999	1.19
Michigan	49200-49299	1.19
Michigan	ALL OTHERS	1.13

Minnesota	55000-55499	1.07
Minnesota	55800-55999	1.02
Minnesota	56400-56499	1.02
Minnesota	ALL OTHERS	0.98
Mississippi	38700-38899	1.11
Mississippi	39400-39499	1.28
Mississippi	39500-39599	1.40
Mississippi	39700-39799	1.11
Mississippi	ALL OTHERS	1.16
Missouri	63000-63199	1.18
Missouri	63300-63399	1.18
Missouri	63400-63999	1.10
Missouri	64000-64199	1.18
Missouri	64400-64899	1.13
Missouri	65000-65399	1.07
Missouri	ALL OTHERS	0.99
Montana	ALL OTHERS	0.98
Nebraska	68000-68099	1.14
Nebraska	68100-68199	1.19
Nebraska	ALL OTHERS	1.08
Nevada	88900-89199	1.07
Nevada	89300-89399	1.02
Nevada	89400-89599	1.07
Nevada	89700-89799	1.02
Nevada	ALL OTHERS	0.97
New Hampshire	ALL OTHERS	1.02
New Jersey	07000-07399	1.29
New Jersey	07400-07699	1.23
New Jersey	08100-08199	1.23
New Jersey	08400-08699	1.23
New Jersey	ALL OTHERS	1.17
New Mexico	87500-87599	0.92
New Mexico	ALL OTHERS	0.88
New York	09000-09899	1.18
New York	10000-10499	1.36
New York	10500-10999	1.30
New York	11000-11499	1.36
New York	11500-11999	1.30
New York	ALL OTHERS	1.12

North Carolina	28400-28499	1.12
North Carolina	ALL OTHERS	1.07
North Dakota	ALL OTHERS	1.00
Ohio	43000-43199	1.11
Ohio	43200-43299	1.16
Ohio	43300-43399	1.11
Ohio	43400-43599	1.16
Ohio	43600-43699	1.33
Ohio	43900-43999	1.16
Ohio	44000-44099	1.22
Ohio	44100-44199	1.33
Ohio	44200-44599	1.22
Ohio	44700-44999	1.11
Ohio	45000-45199	1.16
Ohio	45200-45299	1.22
Ohio	45300-45399	1.11
Ohio	45400-45599	1.16
Ohio	45600-45799	1.11
Ohio	ALL OTHERS	1.05
Oklahoma	73500-73999	1.01
Oklahoma	74000-74099	1.01
Oklahoma	74300-74399	1.01
Oklahoma	74600-74699	1.01
Oklahoma	74700-74799	1.22
Oklahoma	74800-74899	1.06
Oklahoma	ALL OTHERS	1.11
Oregon	97000-97099	1.10
Oregon	97100-97199	1.05
Oregon	97200-97299	1.10
Oregon	97300-97399	1.00
Oregon	97400-97499	1.05
Oregon	97800-97899	1.00
Oregon	ALL OTHERS	0.95
Pennsylvania	15000-15299	1.12
Pennsylvania	18900-18999	1.12
Pennsylvania	19000-19199	1.18
Pennsylvania	19300-19499	1.12
Pennsylvania	ALL OTHERS	1.06
Puerto Rico	ALL OTHERS	0.85
Rhode Island	ALL OTHERS	1.01

South Carolina	29000-29399	1.05
South Carolina	29500-29599	1.25
South Carolina	29600-29799	1.04
South Carolina	ALL OTHERS	1.09
South Dakota	ALL OTHERS	0.95
Tennessee	37000-37199	1.12
Tennessee	37200-37299	1.23
Tennessee	37300-37399	1.12
Tennessee	37400-37499	1.12
Tennessee	37500-37599	1.18
Tennessee	37700-37899	1.12
Tennessee	37900-37999	1.18
Tennessee	38000-38099	1.12
Tennessee	38100-38199	1.18
Tennessee	38300-38399	1.12
Tennessee	38400-38499	1.18
Tennessee	ALL OTHERS	1.07
Texas	75000-75099	1.27
Texas	75100-75199	1.15
Texas	75200-75299	1.27
Texas	75500-75699	1.15
Texas	76000-76099	1.15
Texas	76100-76199	1.27
Texas	76300-76399	1.15
Texas	76400-76999	1.09
Texas	77000-77099	1.33
Texas	77300-77399	1.33
Texas	77600-77799	1.33
Texas	77800-78099	1.15
Texas	78400-78499	1.33
Texas	78500-78699	1.09
Texas	78800-78999	1.09
Texas	79000-79199	1.15
Texas	79200-79299	1.09
Texas	79400-79499	1.39
Texas	79500-79799	1.15
Texas	79800-79999	1.09
Texas	ALL OTHERS	1.21
Utah	84000-84499	1.00
Utah	ALL OTHERS	0.95
Vermont	ALL OTHERS	0.97

Virginia	22000-22399	1.10
Virginia	23300-23599	1.05
Virginia	ALL OTHERS	1.00
Washington	98000-98599	0.99
Washington	99000-99299	0.99
Washington	ALL OTHERS	0.94
West Virginia	25000-25399	1.07
West Virginia	26000-26099	1.07
West Virginia	ALL OTHERS	1.02
Wisconsin	53100-53299	1.09
Wisconsin	53400-53499	1.17
Wisconsin	53700-53799	1.02
Wisconsin	54500-54599	0.93
Wisconsin	54600-54699	0.88
Wisconsin	54800-54899	0.93
Wisconsin	ALL OTHERS	0.98
Wyoming	ALL OTHERS	0.97

SERFF Tracking Number:	*AMRP-126675679*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*46023*
Company Tracking Number:	*A3099AC-AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.006 Plan F (High) 2010*
Product Name:	*2010 Med Supp AR Corp - Plan HdF*		
Project Name/Number:	*2010 Med Supp AR Corp - Plan HdF/A3099AC-AR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	07/13/2010

Comments:

Attachment:

Compliance Certification - ARCIC HDF - AR.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application		

Bypass Reason: Application previously approved. Form C-1031 approved on 2/27/08. SERFF # AMRP-125379102.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	07/13/2010

Comments:

Attachment:

U3100ACAR Rev. 0610 (12-114-3321-XXXX-AR).pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Accepted for Informational Purposes	07/13/2010

Comments:

Attachment:

AR Corp Cover Letter - Arkansas - Plan HdF.pdf

American Republic Corp
Insurance Company
P. O. Box 2780, Omaha, NE 68103-2780

To: Department of Insurance

RE: Forms A3099AC-AR (Medicare Supplement Plan HdF) and U3100ACAR Rev. 0610 (Outline of Coverage)

I certify the policy form being filed complies with Rule 19, Rule 49 and ACA 23-79-138.

I also certify the form being filed meet minimum requirements of the Flesch reading ease policy simplification test, and that: the Flesch reading ease test has been applies to each from, and each from reaches a readability score of at least 40. Also the type size is at least 10 point, one point leaded.

Christopher Aasland, FSA, MAAA
Vice President and Actuary

Date: June 23, 2010

American Republic Corp Insurance Company / National Headquarters, Des Moines, Iowa 50309

Outline of Medicare Supplement Coverage - Benefit Plans A, F, F*, K & L

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS included in A, B, C, D, F, F*, G, M and N. ***Hospitalization:*** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. ***Medical Expenses:*** Part B coinsurance (20% of Medicare approved expenses, or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments). ***Blood:*** First 3 pints of blood each year. ***Hospice:*** Part A coinsurance.

A	B	C	D	F	F*	G	K**	L**	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance		Basic Benefits, including 100% Part B coinsurance	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for Emergency Room
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit*** [$4,620]; paid at 100% after limit reached	Out-of-pocket limit*** [$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Plans K and L cost share differently than Plans A, B, C, D, F, F*, G, M or N. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare Approved Amounts, called "Excess Charges". You will be responsible for paying "Excess Charges".

***The out-of-pocket annual limit will increase each year for inflation.

NOTICE TO BUYER: This policy may not cover all of your **medical** expenses.

PREMIUM INFORMATION

We guarantee to renew your policy as long as you live if you pay your premiums when due.

Premiums may change because of a change of residence or as Medicare benefits change. We can only raise your premium if we raise the premium for all policies like yours in your state. No premium change may be made on an individual basis. We will notify you of the new premium at least 31 days before the next due date. You have a 31-day grace period to pay your premium. Please refer to the attached rate schedule.

Applicant's premium at issue age _____ (Age) for each plan available on _____ (Date) is:

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF	Plan K	Plan L
_____	_____	_____	_____	_____

Spouse's premium at issue age _____ (Age) for each plan available on _____ (Date) is: (if applying)

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF	Plan K	Plan L
_____	_____	_____	_____	_____

MODE FACTORS

Monthly Direct Bill: [0.087]
Quarterly: [0.25]
Semiannual: [0.50]
Annual: [0.08334]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your Insurance Company.

RIGHT TO RETURN POLICY

Please read this policy and the attached Application carefully. If you find that you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, [P.O. Box 2780, Omaha, Nebraska 68103-2780], together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid less the amount of any claims paid. If the amount of claims paid by us exceeds the amount of premiums paid by you, you shall reimburse us the difference. Then, the policy will be void from the beginning as if no policy had been issued.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not fully cover all of your medical costs. Neither American Republic Corp Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" government publication for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. This paragraph does not apply to you if you are 65 or older and within 6 months of becoming eligible for Medicare. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN A
A3100AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
113.36	113.36	128.29	128.29	133.36	133.36	150.92	150.92

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
118.33	118.33	133.92	133.92	139.22	139.22	157.55	157.55

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
340.04	340.04	384.83	384.83	400.05	400.05	452.74	452.74

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
680.09	680.09	769.65	769.65	800.11	800.11	905.48	905.48

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,360.17	1,360.17	1,539.30	1,539.30	1,600.21	1,600.21	1,810.95	1,810.95

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN A
A3100AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,428.87	1,428.87	1,617.04	1,617.04	1,681.02	1,681.02	1,902.41	1,902.41

Arkansas

Medicare Supplement Rates

Zip Codes 722

Effective 6-1-2010

PLAN A
A3100AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
131.68	131.68	149.02	149.02	154.91	154.91	175.32	175.32

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
137.46	137.46	155.56	155.56	161.72	161.72	183.02	183.02

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
395.00	395.00	447.02	447.02	464.71	464.71	525.91	525.91

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
790.00	790.00	894.04	894.04	929.42	929.42	1,051.82	1,051.82

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,580.00	1,580.00	1,788.08	1,788.08	1,858.83	1,858.83	2,103.63	2,103.63

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN A
A3100AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
125.95	125.95	142.54	142.54	148.18	148.18	167.69	167.69

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
131.48	131.48	148.80	148.80	154.69	154.69	175.06	175.06

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
377.83	377.83	427.59	427.59	444.50	444.50	503.04	503.04

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
755.65	755.65	855.17	855.17	889.01	889.01	1,006.08	1,006.08

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,511.30	1,511.30	1,710.34	1,710.34	1,778.01	1,778.01	2,012.16	2,012.16

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN F
A3101AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
155.51	155.51	176.00	176.00	182.96	182.96	207.05	207.05

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
162.34	162.34	183.73	183.73	190.99	190.99	216.15	216.15

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
466.50	466.50	527.95	527.95	548.83	548.83	621.11	621.11

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
933.00	933.00	1,055.90	1,055.90	1,097.65	1,097.65	1,242.23	1,242.23

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,866.00	1,866.00	2,111.79	2,111.79	2,195.30	2,195.30	2,484.45	2,484.45

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN F
A3101AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
163.37	163.37	184.88	184.88	192.20	192.20	217.51	217.51

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
170.54	170.54	193.00	193.00	200.64	200.64	227.06	227.06

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
490.06	490.06	554.61	554.61	576.54	576.54	652.48	652.48

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
980.12	980.12	1,109.22	1,109.22	1,153.09	1,153.09	1,304.97	1,304.97

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,960.24	1,960.24	2,218.44	2,218.44	2,306.17	2,306.17	2,609.93	2,609.93

Arkansas

Medicare Supplement Rates

Zip Codes 722

Effective 6-1-2010

PLAN F
A3101AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
180.65	180.65	204.44	204.44	212.52	212.52	240.52	240.52

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
188.58	188.58	213.42	213.42	221.86	221.86	251.08	251.08

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
541.90	541.90	613.27	613.27	637.52	637.52	721.50	721.50

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,083.79	1,083.79	1,226.55	1,226.55	1,275.05	1,275.05	1,442.99	1,442.99

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
2,167.58	2,167.58	2,453.09	2,453.09	2,550.09	2,550.09	2,885.98	2,885.98

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN F
A3101AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
172.79	172.79	195.55	195.55	203.28	203.28	230.06	230.06

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
180.38	180.38	204.14	204.14	212.21	212.21	240.16	240.16

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
518.34	518.34	586.61	586.61	609.81	609.81	690.13	690.13

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,036.67	1,036.67	1,173.22	1,173.22	1,219.61	1,219.61	1,380.26	1,380.26

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
2,073.34	2,073.34	2,346.43	2,346.43	2,439.22	2,439.22	2,760.51	2,760.51

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PLAN HDF
A3099AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
57.44	57.44	66.47	66.47	67.58	67.58	78.20	78.20

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
59.97	59.97	69.39	69.39	70.55	70.55	81.63	81.63

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
172.33	172.33	199.39	199.39	202.74	202.74	234.58	234.58

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
344.66	344.66	398.79	398.79	405.48	405.48	469.17	469.17

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
689.31	689.31	797.58	797.58	810.95	810.95	938.33	938.33

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PLAN HDF
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Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
60.35	60.35	69.83	69.83	71.00	71.00	82.15	82.15

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
63.00	63.00	72.90	72.90	74.12	74.12	85.76	85.76

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
181.03	181.03	209.47	209.47	212.98	212.98	246.43	246.43

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
362.07	362.07	418.93	418.93	425.96	425.96	492.86	492.86

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
724.12	724.12	837.86	837.86	851.91	851.91	985.72	985.72

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APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
66.73	66.73	77.21	77.21	78.51	78.51	90.84	90.84

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
69.66	69.66	80.61	80.61	81.95	81.95	94.83	94.83

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
200.18	200.18	231.63	231.63	235.50	235.50	272.50	272.50

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
400.36	400.36	463.24	463.24	471.01	471.01	544.99	544.99

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
800.71	800.71	926.48	926.48	942.01	942.01	1,089.98	1,089.98

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PLAN HDF
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APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
63.83	63.83	73.86	73.86	75.09	75.09	86.89	86.89

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
66.63	66.63	77.10	77.10	78.39	78.39	90.71	90.71

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
191.47	191.47	221.55	221.55	225.26	225.26	260.65	260.65

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
382.95	382.95	443.11	443.11	450.53	450.53	521.30	521.30

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
765.89	765.89	886.20	886.20	901.05	901.05	1,042.59	1,042.59

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PLAN K
A3104AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
80.41	80.41	91.00	91.00	94.60	94.60	107.06	107.06

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
83.94	83.94	94.99	94.99	98.75	98.75	111.76	111.76

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
241.20	241.20	272.97	272.97	283.77	283.77	321.14	321.14

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
482.41	482.41	545.95	545.95	567.54	567.54	642.29	642.29

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
964.81	964.81	1,091.89	1,091.89	1,135.07	1,135.07	1,284.57	1,284.57

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PLAN K
A3104AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
84.47	84.47	95.59	95.59	99.37	99.37	112.46	112.46

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
88.18	88.18	99.79	99.79	103.74	103.74	117.40	117.40

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
253.39	253.39	286.76	286.76	298.10	298.10	337.36	337.36

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
506.77	506.77	573.52	573.52	596.20	596.20	674.73	674.73

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,013.54	1,013.54	1,147.04	1,147.04	1,192.40	1,192.40	1,349.45	1,349.45

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PLAN K
A3104AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,120.74	1,120.74	1,268.36	1,268.36	1,318.52	1,318.52	1,492.18	1,492.18

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PLAN K
A3104AC

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PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,072.02	1,072.02	1,213.21	1,213.21	1,261.19	1,261.19	1,427.31	1,427.31

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PLAN L
A3105AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,327.58	1,327.58	1,502.40	1,502.40	1,561.85	1,561.85	1,767.54	1,767.54

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PLAN L
A3105AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
116.23	116.23	131.53	131.53	136.74	136.74	154.75	154.75

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
121.33	121.33	137.31	137.31	142.74	142.74	161.54	161.54

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
348.66	348.66	394.57	394.57	410.19	410.19	464.20	464.20

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
697.32	697.32	789.14	789.14	820.37	820.37	928.41	928.41

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,394.63	1,394.63	1,578.28	1,578.28	1,640.74	1,640.74	1,856.81	1,856.81

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PLAN L
A3105AC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
128.52	128.52	145.45	145.45	151.20	151.20	171.11	171.11

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
134.17	134.17	151.83	151.83	157.84	157.84	178.63	178.63

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
385.54	385.54	436.31	436.31	453.57	453.57	513.30	513.30

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
771.07	771.07	872.61	872.61	907.14	907.14	1,026.60	1,026.60

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,542.14	1,542.14	1,745.22	1,745.22	1,814.27	1,814.27	2,053.20	2,053.20

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PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
122.93	122.93	139.12	139.12	144.63	144.63	163.67	163.67

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
128.33	128.33	145.23	145.23	150.98	150.98	170.86	170.86

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
368.77	368.77	417.34	417.34	433.85	433.85	490.98	490.98

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
737.55	737.55	834.67	834.67	867.70	867.70	981.97	981.97

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,475.09	1,475.09	1,669.34	1,669.34	1,735.39	1,735.39	1,963.93	1,963.93

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,100]	$0	[$1,100] (Part A deductible)
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$550]	[$550] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$155] of Medicare Approved Amounts* (Part B deductible)	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts* (Part B deductible)	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed [$155] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,100]	[$1,100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$550]	[$550] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed [$155] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% of a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,100]	[$1,100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$550]	[$550] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed [$155] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% of a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

PLAN K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,100]	[$550] (50% of Part A deductible)	[$550] (50% of Part A deductible)◆
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$550]	[$550] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$68.75] a day	Up to [$68.75] a day◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%◆
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance◆

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$155] of Medicare Approved Amounts****	$0	$0	[$155] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4,620])*
BLOOD			
First 3 pints	$0	50%	50%◆
Next [$155] of Medicare Approved Amounts****	$0	$0	[$155] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [$4,620] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed [$155] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN K (continued)

MEDICARE (PARTS A AND B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$155] of Medicare Approved Amounts*****	$0	$0	[$155] (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,100]	[$825] (75% of Part A Deductible)	[$275] (25% of Part A Deductible)◆
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$550]	[$550] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$103.13] a day	Up to [$34.37] a day◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%◆
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance◆

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$155] of Medicare Approved Amounts****	$0	$0	[$155] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2,310])*
BLOOD			
First 3 pints	$0	75%	25%◆
Next [$155] of Medicare Approved Amounts****	$0	$0	[$155] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [$2,310] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed [$155] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN L (continued)

MEDICARE (PARTS A & B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$155] of Medicare Approved Amounts*****	$0	$0	[$155] (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	15%	5%◆

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

American Republic Corp
Insurance Company
P. O. Box 2780, Omaha, NE 68103-2780

NAIC: 67679 June 23, 2010

Hon. Michael T. McRaith, Director of Insurance
Department of Insurance
320 W. Washington St., 4th Fl.
Springfield, IL 62767

Attention: Stephanie Fowler

RE: Individual Medicare Supplement Plan
Plan High Deductible F – A3099AC-AR
Outline of Coverage – U3100ACAR Rev.0610

Dear Ms. Fowler:

Please find enclosed the above-captioned forms for your Departments review. Form A3099AC-AR (Plan High Deductible F) is new and does not replace any previously approved forms. This form was developed in accordance with the NAIC Medicare Supplement Model Regulation, as amended.

This form will be marketed by licensed agents to Arkansas residents who are eligible for Medicare and will be marketed through face to face contact as well as telephone solicitation.

Form U3100ACAR Rev.0610 (Outline of Coverage) is being updated to include the High Deductible F plan information. This form was previously approved by your Department on August 6, 2009 through SERFF Tracking #AMRP-126211046.

The forms employ easy to read language. Our certification as to the Flesch Readability Score of each policy form is included.

Application form C-1031 previously approved by your Department on February 27, 2008 will be used with this product. You will note that the form is co-branded and will be used by American Republic Insurance Company in the marketing of Medicare Supplement, Short- Term Convalescent Care, and Life insurance coverage. Both American Republic Insurance Company and American Republic Corp Insurance Company are subsidiaries of the mutual insurance holding company, American Enterprise Group Inc.

The Actuarial Memorandum and rates are also included in this filing.

Variable material is bracketed to indicate that they are subject to change. The forms are in final print subject only to minor modification in paper size, stock, color, border, font, company logo and adaptation to computer printing. Depending on printer capabilities, the application will be printed as either simplex or duplex.

Your earliest acknowledgement of this filing would be appreciated. If you have any questions or comments, please contact me. I can be reached at our toll-free number, 1-800-247-2190, ext 2083, by fax at 515-247-2470, or you can email me at sarah.shives@americanenterprise.com.

Sincerely,

Sarah Shives
Compliance Analyst

American Republic Corp Insurance Company
Phone: (515) 245-2083 **Fax**: (515) 247-2470 **e-mail**: sarah.shives@americanenterprise.com